

MEDICAL REVIEW – SOUTHERN SECTION III  
AUDITS AND INVESTIGATIONS  
DEPARTMENT OF HEALTH CARE SERVICES

Inland Empire Health Plan  
Contract Number:

Audit Period:

Report Issued:  
04-35765

January 1, 2013  
Through  
December 31, 2013

November 13, 2014

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## I. INTRODUCTION

Inland Empire Health Plan (IEHP or the Plan) was established in 1994, as the local initiative, Medi-Cal Managed Care health plan in the Inland Empire. IEHP received a Knox-Keene license July 22, 1996 and began operation on September 1, 1996 in both Riverside and San Bernardino counties.

Inland Empire Health Plan provides managed care health services to Medi-Cal beneficiaries under the provision of Welfare and Institutions Code, Section 14087.3. IEHP is a public, non-profit Joint Powers Agency (JPA), Knox-Keene licensed health plan. IEHP is located in Rancho Cucamonga, created by San Bernardino and Riverside counties as a two-plan Medi-Cal managed care model.

IEHP provides health care coverage to eligible Members in areas of San Bernardino and Riverside counties for which it is licensed as a mixed model Health Maintenance Organization (HMO) contracting with 15 Independent Physician Associations (IPAs), 26 hospitals and directly with 513 Primary Care Physicians (PCPs) and 1,016 Specialists.

As of April 1, 2014, Inland Empire Health Plan's enrollment for Medi-Cal, Healthy Kids, and Cal MediConnect was approximately 730,087 Members in Riverside and San Bernardino counties. Enrollment by product line was as follows:

- Medi-Cal Members: 728,735
- Healthy Kids 1,188
- Cal MediConnect 164

## II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of January 1, 2013 through December 31, 2013. The on-site review was conducted from April 7, 2014 through April 18, 2014. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on October 1, 2014 with the Plan. The Plan was allowed 15 calendar days from the date of the exit conference to provide supplemental information addressing the draft audit report finding. The Plan submitted supplemental information after the exit conference which is reflected in this report.

The audit evaluated six categories of performance: Utilization Management (UM), Continuity of Care, Access and Availability of Care, Members' Rights, Quality Management (QI), and Administrative and Organizational Capacity.

### **Category 1 – Utilization Management**

The Plan did not comply with Contract requirements for timely processing of pharmacy Prior Authorizations. The Plan did not routinely meet the 24-hour time frame for authorization of pharmaceuticals, as specified in the Contract.

The Plan's Provider Manual and policies did not reflect the monitoring of the Primary Care Provider (PCP) referral log by IEHP on a routine basis. The Plan has not implemented a system to track open or unused prior authorization referrals.

The Plan did not have clearly defined procedures reflected in the Provider Policy and Procedure Manual of Approved Referral File reviews of UM Delegates. The Plan's Provider Manual and policies were not consistent with current practice with regards to monitoring and oversight of PCP referral logs for Primary Care Providers within the Independent Practice Association network.

### **Category 2 – Case Management and Coordination of Care**

The Plan is required to ensure the provision of Comprehensive Medical Case Management Services to each Member. These services are provided through either Basic or Complex Case Management activities, based on the medical needs of the member.

Based on the verification study, the Plan lacks:

- Documentation for coordination of care between PCPs (Primary Care Physicians) and specialists for California Children's Services (CCS) and Early Intervention/Developmental Disabilities (EI/DD) Members.
- Documentation for the completion of Initial Health Assessments (IHA) in the medical records, and in some instances, IHAs completed outside of required timeframes.

### **Category 3 – Access and Availability of Care**

The Plan was compliant with the requirements in this Category.

### **Category 4 – Members' Rights**

The Plan failed to notify the Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) Contract Manager and the DHCS Information Security Officer of HIPAA breaches within the required time frame, as mandated by the Contract.

### **Category 5 – Quality Management**

The verification studies of medical records from the Plan's provider locations indicate that the providers failed to maintain complete and accurate medical records for all Members. In a separate verification study of Informed Consent (IC) documentation, the findings include failure to maintain IC forms in the Member's medical record.

### **Category 6 – Administrative and Organizational Capacity**

The Plan did not ensure that all potential fraud, waste, and abuse cases were reported to DHCS within the time frames required by the Contract.

### **III. SCOPE/AUDIT PROCEDURES**

#### **SCOPE**

This audit was conducted by the Department of Health Care Services (DHCS) Medical Review Branch to ascertain that the medical services provided to Plan Members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's Two-Plan Contract.

#### **PROCEDURE**

The on-site audit of Inland Empire Health Plan (IEHP) was conducted from April 7, 2014 through April 18, 2014. The audit included a review of the Plan's Contract with DHCS, its policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

#### **Category 1 – Utilization Management**

Prior Authorization Request: 20 medical and 20 pharmacy prior authorizations were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to Members and Providers.

Appeals Process: 31 appeal requests were reviewed for appropriate and timely adjudication.

#### **Category 2 – Case Management and Coordination of Care**

California Children's Services (CCS): 42 medical records were reviewed for evidence of coordination of care between the Plan and CCS providers.

Early Intervention and Developmental Disabilities: 42 medical records were reviewed for evidence of coordination of care between the Plan and Regional Center.

Individual Health Assessment: 42 medical records were reviewed for completeness and timely completion.

#### **Category 3 – Access and Availability of Care**

Emergency Service Claims: 20 emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: 20 family planning claims were reviewed for appropriate and timely adjudication.

#### **Category 4 – Member’s Rights**

Grievance Procedures: 61 grievances were reviewed. Thirty-one (31) Quality of Care grievances and thirty (30) Quality of Services grievances files were reviewed for timely resolution, response to complaint, and submission to the appropriate level of review.

#### **Category 5 – Quality Management**

Medical Records: 126 medical records were reviewed for completeness.

Informed Consent: 29 informed consent records were reviewed for completeness of the Informed Consent form number PM 330.

#### **Category 6 – Administrative and Organizational Capacity**

New Provider Training: 12 new provider training records were reviewed for timely Medi-Cal Managed Care program training.

A description of the findings for each category is contained in the following report.

## CATEGORY 1 - UTILIZATION MANAGEMENT

1.2

### PRIOR AUTHORIZATION REVIEW REQUIREMENTS

**Prior Authorization and Review Procedures:**

Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements...(as required by Contract)

2-Plan Contract A.5.2.A, B, D, F, H, and I.

**Exceptions to Prior Authorization:**

Prior Authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

2-Plan Contract A.5.2.G

**Notification of Prior Authorization Denial, Deferral, or Modification:**

Contractor shall notify Members of a decision to deny, defer, or modify requests for prior authorization, in accordance with Title 22 CCR Sections 51014.1 and 53894 by providing written notification to Members and/or their authorized representative...This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, and 53894, and Health and Safety Code Section 1367.01.

2-Plan Contract A.13.8.A

### **SUMMARY OF FINDINGS:**

The Plan has policies and procedures for prior authorization requests for medical and pharmacy services. Review criteria are applied using nationally recognized clinical criteria. Inter-rater Reliability Studies are used to ensure consistent application of the Utilization Management guidelines.

The Plan has qualified staff to review the requested services for medical necessity. A medical director is accountable for oversight of all review processes and has direct responsibility for all denied decisions.

Prior authorization requirements are not applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, HIV testing and other confidential services. The Plan notifies Members of a decision to deny, defer or modify requests for prior authorization by providing written notification to Members as required by Contract.

Verification Study:

A total of 40 prior authorizations, twenty (20) medical and twenty (20) pharmacy, were reviewed for the verification study. All twenty (20) medical prior authorizations were adjudicated appropriately and in a timely manner. Twenty (20) pharmacy prior authorizations were reviewed appropriately by a pharmacist. However, eighteen (18) out of 20 pharmacy services did not meet the 24-hour turnaround time frame. According to the Plan's policy, *Prior Authorization for Non-Formulary Drugs-Non-Medicare* (MED\_PHR5.1), section E, "all completed pharmacy exemption requests (PER) are reviewed and acted on within 24 hours." This is in agreement with the Contract which stipulates for prior authorization, "Pharmaceuticals: 24 hours on all drugs that require prior authorization in accordance with Welfare and Institutions Code, Section 14185 or any future amendments thereto." (Contract Reference: 2-Plan Exhibit A, Attachment 5.3.F)

The majority of the pharmacy exemption requests (PER) prior authorizations reviewed were outside the 24-hour turnaround time specified in the Contract.

Decisions are clearly documented and criteria utilized for denials are present in the case file. In the Notice of Action letters, details of the decision are clearly documented.

### **RECOMMENDATION:**

Adhere to the Plan's policy, Prior Authorization for Non-Formulary Drugs-Non-Medicare (MED\_PHR 5), and the Contract for a 24-hour time frame for pharmacy authorizations.

<b>1.3</b>	<b>REFERRAL TRACKING SYSTEM</b>
<p><b>Referral Tracking System:</b>  Contractor is responsible to ensure that the UM program includes: ... An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.  2-Plan Contract A.5.1.F</p>	

**SUMMARY OF FINDINGS:**

The Plan's Provider Manual outlines the requirements for referral tracking. The Plan delegates the responsibility for referral tracking to its Primary Care Providers (PCPs). All PCPs, those in IEHP's direct network and those in the Plan's Independent Physician Associations (IPAs), are required to maintain a referral tracking log that is up to date and available for review by the Plan.

In an interview with Plan personnel, it was stated that the referral tracking logs are reviewed as part of the facility site review process of provider offices (for both providers in the IPAs and those in IEHP's direct network), with a full review occurring every 3 years, and a focused review every 18 months. This oversight process is not specified in the Provider Manual, however, nor are there any policies and procedures which address referral tracking or the Plan's oversight of the referral tracking process. There is no interim monitoring of the referral logs, nor does the Plan or the IPAs track open or unused referrals. (Contract Reference: 2-Plan Exhibit A, Attachment 5.1.F)

**RECOMMENDATIONS:**

- Amend Provider Manual and policies to reflect monitoring of the PCP referral log by IEHP on a routine basis (e.g., every 18 months during facility site reviews).
- Implement a process to track open and unused referrals, as stipulated in the Contract.

<b>1.5</b>	<b>DELEGATION OF UTILIZATION MANAGEMENT</b>
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**Delegated Utilization Management (UM) Activities:**

Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. 2-Plan Contract A.5.5

**SUMMARY OF FINDINGS:**

The Plan delegated Utilization Management (UM) functions to ten Independent Practice Associations (IPAs) and one Health Maintenance Organization (Kaiser), during the audit period. IEHP’s direct network is monitored in the same manner as the IPAs and is considered by the Plan to be its ‘direct’ IPA. The direct network has approximately 40 percent of IEHP Members, and the IPAs (including Kaiser), approximately 60 percent of IEHP Members. The IPAs are paid by IEHP on a capitated basis.

IEHP has a comprehensive delegation oversight process, including pre-delegation audits, annual onsite delegation oversight audits, and monthly and quarterly reporting between IEHP and its delegates. The Plan acts on deficiencies noted on annual audits and detected in monthly reporting, as evidenced by the presence of corrective action plans, verified in minutes from the Quality Management Committee, and the Delegation Oversight Committee.

The Plan modified its annual “Approved Referral File Review”, a part of the Delegation Oversight Annual Audit, during mid-2013, switching from a review of 40 approved referral files to a smaller file review performed quarterly. Three Delegation Oversight Annual Audits reviewed from the audit period reflected a smaller sample size, yet this procedural change was not reflected in the Provider Policy and Procedure Manual.

Pursuant to the Provider Manual *Referral Tracking Log* (MC\_14C.1.a.1 PCP), primary care providers, whether within an IPA or with the direct network, are required to maintain a referral tracking log for their Members. Policies do not state how often and in what manner IEHP will provide oversight of that log, nor is review of the log included in delegation oversight policies. Although the Plan stated verbally that it reviews these logs every 18 months during full or interim Facility Site Reviews, no written evidence of this practice was found.

**RECOMMENDATIONS:**

- Amend policies and procedures, including the Provider Manual, to be consistent with current practice with regards to Authorized Referral Audits of UM Delegates.
- Amend policies and procedures to be consistent with current practice with regards to monitoring and oversight of primary care provider referral logs for Primary Care Providers within the Independent Practice Association network.

**CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE**

2.2

**CALIFORNIA CHILDREN’S SERVICES (CCS)**

**California Children's Services (CCS):**

Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program....(as required by Contract)

Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program...for the coordination of CCS services to Members.  
2-Plan Contract A.11.9.A, B

**SUMMARY OF FINDINGS:**

The Plan has policies and procedures for identifying and referring children with California Children's Services (CCS) eligible conditions to the local CCS program. The policy states that the CCS program services must be provided by CCS paneled/approved providers. Authorization for such services must be received from the CCS program. The policy further states that Inland Empire Health Plan (IEHP) contract Providers will be responsible for identifying and referring children with CCS eligible conditions to the local CCS program.

Through the Member Handbook, the Plan informs Members that the CCS program is a separate program from IEHP. The CCS program pays for medical services for children with special medical needs. Members receive care from CCS doctors for the CCS eligible condition. Members enrolled in the CCS program, are still an IEHP Member and IEHP still provide other health care. Information about the CCS program can be obtained by calling IEHP's Member Services.

The Plan provides training to the contracted Independent Physician Associations (IPAs) in the network on the CCS program, and facilitates the link between the IPA Care Management (CM) and CCS staff. The Provider In-Service Handbook contains information regarding the CCS program and instructions for referral and CM for IPAs, Primary Care Physicians (PCPs). The IPA must report all Members referred to CCS on a monthly CCS CM log to the Plan for the purpose of review and monitoring.

The Plan has a Memorandum of Understanding between San Bernardino and Riverside County Department of Public Health and CCS to coordinate care for the CCS Program. Children identified as CCS eligible gain access to the CCS program through referrals from PCPs, hospital personnel, IEHP Utilization Management/CM staff, community agencies or schools.

In a verification study, forty-two (42) medical records for Members with CCS-eligible conditions were reviewed. Thirteen of 42 medical records failed to document coordination of services between Primary Care Physician, CCS specialty providers and the local CCS program. Nine of 13 medical records for Inland Empire Health Plan with CCS eligible conditions lacked documentation of baseline health assessments and diagnosis evaluations to establish CCS eligible condition.

Although the Plan has written policies for identifying and referring children with California Children's Services (CCS) eligible conditions to the local CCS program, there was no evidence of monitoring and tracking Members for coordination of care between Primary Care Physicians and specialty providers.

**RECOMMENDATION:**

Ensure that CCS-eligible Members are monitored and tracked for coordination of care between Primary Care Physicians and specialty providers occurs.

2.3	<b>EARLY INTERVENTION SERVICES / DEVELOPMENTAL DISABILITIES</b>
<p><b>Services for Persons with Developmental Disabilities:</b>  Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.</p> <p>Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall participate with Regional Center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services, which need to be provided to the Member.</p> <p>Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers...for the coordination of services for Members with developmental disabilities.  2-Plan Contract A.11.10.A, C, E</p> <p><b>Early Intervention Services:</b>  Contractor shall develop and implement systems to identify children who may be eligible to receive services from the Early Start program and refer them to the local Early Start program....Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation.  2-Plan Contract A.11.11</p>	

**SUMMARY OF FINDINGS:**

The Plan has developed and implemented systems to identify children who may be eligible to receive services from the Early Start program. These Members are being referred to the local Early Start Program.

A Memorandum of Understanding for the coordination of services has been executed, implemented and followed by the Plan. The Plan and the Regional Center facilitate coordination of comprehensive services and medical care for the Regional Center and Early Start eligible Members.

Case management notes show the Plan provides case management and care coordination to the Members to ensure the provision of all medically necessary covered services. Case management records for five (5) eligible Members were reviewed to evaluate the effectiveness of the Plan's case management function. The records reflected care coordination between Inland Empire Health Plan and Inland Regional Center.

In a verification study, a total of forty-two (42) medical records with Early Intervention/Developmental Disabilities (EI/DD) eligible conditions were reviewed. Three of 42 records lacked documentation of coordination of care with local programs to provide continuity of the medically necessary covered diagnostic, preventive and treatment services for its Members. Also, lacking in the three records is documentation of the Members EI/DD medical condition or assessments to identify EI/DD conditions.

**RECOMMENDATION:**

Develop a monitoring system to ensure that the Early Intervention/Developmental Disabilities (EI/DD) eligible Members receive primary care services and there is coordination of care that occurs between Primary Care Provider (PCP) and EI/DD specialists.

2.4	<b>INITIAL HEALTH ASSESSMENT</b>
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**Provision of Initial Health Assessment:**

Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22, CCR, Sections 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.

2-Plan Contract A.10.3.A

Provision of IHA for Members under Age 21

For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 60 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.

For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.

2-Plan Contract A.10.5

IHAs for Adults, Age 21 and older

- 1) Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.
- 2) Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes, but is not limited to:
  - a) blood pressure,
  - b) height and weight,
  - c) total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,
  - d) clinical breast examination for women over 40,
  - e) mammogram for women age 50 and over,
  - f) Pap smear (or arrangements made for performance) on all women determined to be sexually active,
  - g) chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,
  - h) screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk,
  - i) health education behavioral risk assessment.

2-Plan Contract A.10.6

Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement.

2-Plan Contract A.10.3.D

**SUMMARY OF FINDINGS:**

The Plan has policies and procedures to address the completion of the Initial Health Assessment (IHA) for Members under the age of 18 months and for those Members over the age of 18 months to include completion within appropriate timeframes and office visit criteria.

Pursuant to the Plan's Provider Manual *Initial Health Assessment* (MC\_10A.1), primary care physicians, must perform an Initial Health Assessment for all new Members age 18 months and older within 120 days of enrollment and all Members under the age of 18 months within 60 days of enrollment.

The Plan informs Members of the IHA requirement through an initial "Welcome Letter" upon enrollment and encourages Members to call their Primary Care Physician within the appropriate timeline depending on the age of the Member. The Member Handbook states that within two or four months of joining Inland Empire Health Plan, the Member's doctor will perform an Initial Health Assessment during the first appointment.

In a verification study, forty-two (42) medical records were reviewed. Three of 42 medical records exceeded the time frame to perform the IHA.

**RECOMMENDATION:**

Ensure that Providers complete the Individual Health Assessment for all new Members within the timelines stipulated in the Contract.

## CATEGORY 4 – MEMBERS’ RIGHTS

4.3

### CONFIDENTIALITY RIGHTS

#### Members’ Right to Confidentiality

Contractor shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

- 1) Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the network.
- 2) Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain Member's consent prior to release of confidential information, unless such consent is not required pursuant to Title 22 CCR Section 51009.

2-Plan Contract A.13.1.B

#### Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:

Contractor agrees:

B. Safeguards—To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains or transmits on behalf of DHCS; and to prevent use or disclosure of PHI other than as provided for by this Contract.....

H. Notification of Breach—During the term of this Agreement:

- 1). Discovery of Breach. To notify DHCS immediately by telephone call plus e-mail or fax upon the discovery of breach of security of PHI in computerized form if the PHI was, or is reasonably believed to have been, acquired by an unauthorized person; or within 24 hours by e-mail or fax of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of this Contract...
- 2). Investigation of Breach. To immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, to notify the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer...

I. Notice of Privacy Practices. To produce a Notice of Privacy Practices (NPP) in accordance with standards and requirements of HIPAA, the HIPAA regulations, applicable State and Federal laws and regulations, and Section 2.A. of this Exhibit...

2-Plan Contract G.3.B, H, and I

### **SUMMARY OF FINDINGS:**

The Plan's Policy, *Members' Rights and Responsibilities* (MC\_22A) establish Inland Empire Health Plan's (IEHP's) Members' rights and responsibilities. The HIPAA – Protected Health Information (MC\_23C) establishes the Plan's policy related to access, use and disclosure of Member information that includes administrative, physical, and technical safeguards.

The Plan's Policy, *2013 HIPAA Program Descriptions* (PRO/CMP 04a) stipulate the Plan must disclose Protected Health Information (PHI) to Members and contracted government agency for healthcare compliance investigation or review or enforcement action. The Plan is permitted to use and disclose PHI without a Member's authorization for treatment, payment, or health care operations related to IEHP plans or program.

Policy *Notification of Privacy Incident and Breach Risk Assessment and Reporting* (PRO\_CMP 04n) stipulate that notice of breach is provided to the Department of Health Care Services (DHCS) Privacy Officer, DHCS Information Security Officer, and DHCS Medi-Cal Managed Care Division (MMCD) Contract Manager by telephone and notified by email or fax within 24 hours of occurrence. For discovery of a breach, the Plan submits a report within ten working days to the DHCS Privacy Officer and Department Health Care Services Information Security Officer.

The Plan's Policy, *HIPAA Walk-thrus* (PRO\_CMP 04m) states the Compliance Department staff conducts random HIPAA walk-thrus at the Plan to ensure Team Members are following procedures for PHI protection.

Members are informed through the Member Handbook of their rights to confidentiality for medical information and records. The Plan's Notice of Privacy Practices (NPP) is distributed to new Members upon enrollment and distributed annually to all Members. The Notice of Privacy Practices is also posted on the Plan's website.

A Code of Business Conduct and Ethics is maintained on the Plan's website for Providers. Providers are informed of the importance of safeguarding PHI and variety of ways to report potential privacy breach through policies and procedures. The Compliance Officer is responsible for overseeing the reporting and investigation of the privacy breaches. The Plan provides HIPAA Compliance training for new hires at the Plan facility.

The Contract stipulates that upon discovery of a breach, notifications shall be provided to the DHCS Privacy Officer, Information Security Officer and DHCS Medi-Cal Managed Care Division (MMCD) Contract Manager, immediately by telephone or within 24 hours by e-mail or fax. Seven (7) HIPAA cases were received for the audit. Based on the review of seven cases, the Initial Notification of Breach for five cases was only sent to the DHCS Privacy Officer and not submitted to the DHCS MMCD Contract Manager and the DHCS Information Security Officer as required by the Contract. One (1) of the five cases was not reported within the required 24-hour time frame as established in the Contract. The breach was discovered on a Friday and the Plan did not notify DHCS until Wednesday of the following week. For two (2) cases, the Plan investigated and verified suspected breaches to be non-reportable incidents. (Contract Reference: 2-Plan Exhibit G.3.H)

**RECOMMENDATIONS:**

- Ensure that actual and suspected breaches are reported to the Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) Contracting Officer, the DHCS Privacy Officer and the DHCS Information Security Officer.
- Ensure that the initial notification of PHI breach is submitted to DHCS personnel within the required time frame as stipulated in the DHCS Contract.

## CATEGORY 5 – QUALITY MANAGEMENT

5.5

### MEDICAL RECORDS

#### Medical Records

A. General Requirement

Contractor shall ensure that appropriate medical records for Members, pursuant to Title 28, CCR, Section 1300.80(b)(4), Title 42 United States Code (USC) Section 1396a(w), 42 CFR 456.111 and 42 CFR 456.211, shall be available to health care providers at each encounter in accordance with Title 28, CCR Section 1300.67.1(c) and Title 22 CCR Section 53861 and MMCD Policy Letter 02-02.

B. Medical Records

Contractor shall develop, implement and maintain written procedures pertaining to any form of medical records:

- 1) For storage and filing of medical records including: collection, processing, maintenance, storage, retrieval identification, and distribution.
- 2) To ensure that medical records are protected and confidential in accordance with all Federal and State law.
- 3) For the release of information and obtaining consent for treatment.
- 4) To ensure maintenance of medical records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).

C. On-Site Medical Records

Contractor shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each site.

D. Member Medical Record

Contractor shall ensure that a complete medical record is maintained for each Member in accordance with Title 22 CCR Section 53861, that reflects all aspects of patient care, including ancillary services, and at a minimum includes:

- 1) Member identification on each page; personal/biographical data in the record.
- 2) Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.
- 3) All entries dated and author identified; for Member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment.
- 4) The record shall contain a problem list, a complete record of immunizations and health maintenance or preventive services rendered.
- 5) Allergies and adverse reactions are prominently noted in the record.
- 6) All informed consent documentation, including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6, if applicable.
- 7) Reports of emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions.
- 8) Consultations, referrals, specialists', pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.
- 9) For medical records of adults, documentation of whether the individual has been informed and has executed an advanced directive such as a Durable Power of Attorney for Health Care.
- 10) Health education behavioral assessment and referrals to health education services.

2-Plan Contract A.4.13.A, B, C and D

#### **SUMMARY OF FINDINGS:**

The Plan's policy, *PCP and IPA Medical Record Requirements (MED\_QM 7.a)* communicates the procedures for medical record documentation and confidentiality standards, including storage and access. The policy communicates standards for the administration and maintenance of medical records by individual practitioners to facilitate communication, coordination and continuity of care, and to promote efficient and effective care. The policy also contains procedures to ensure that a complete medical record is maintained for each Member and reflects all aspects of patient care.

The Plan performs Medical Record Reviews (MRR) using the most current medical record review survey tool issued

by the Department of Health Care Services (DHCS) to assure primary care providers (PCP) and OB/GYNs acting as PCPs are in compliance with the medical record documentation.

In a verification study, 155 medical records were received according to the Contract requirements, including documentation review of medical services and coordination of care. 55 of 155 medical records reviewed did not document a complete record of immunizations, health maintenance, or preventive services rendered. (Contract Reference: 2-Plan Exhibit A, Attachment 4.13.D)

**RECOMMENDATIONS:**

- Ensure that a complete medical record is maintained for each Member.
- Continue to monitor provider compliance with Facility Site Reviews including medical record reviews.

5.6	<b>INFORMED CONSENT</b>
<p><b>Informed Consent</b>  Contractor shall ensure that a complete medical record is maintained for each Member in accordance with Title 22 CCR Section 53861, that reflects all aspects of patient care, including ancillary services, and at a minimum includes: ...All informed consent documentation, including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6, if applicable.  2-Plan Contract A.4.13.D.6</p> <p>Contractor shall ensure that informed consent is obtained from Medi-Cal enrollees for all contraceptive methods, including sterilization, consistent with requirements of Title 22 CCR Sections 51305.1 and 51305.3.  2-Plan Contract A.9.9.A.1</p>	

**SUMMARY OF FINDINGS:**

The Plan's policy, *Family Planning Services* (MC\_10G) indicates that Members have access to family planning services through any family planning provider without prior authorization. The policy indicates that Members of childbearing age may access services from out-of-network family planning providers to temporarily or permanently prevent or delay pregnancy.

The policy includes eligibility criteria for sterilization procedures. In addition, the policy states that the Plan's contracted providers will be required to obtain a sterilization consent form for the designated procedures prior to performing such procedures. The Plan has specific instructions for the completion of the Sterilization Consent Form (PM330).

The Member Handbook informs Members of the family planning services available from any participating provider, both in and out-of-network, without prior authorization, as well as from non-participating providers.

Through the Provider Manual, Providers are informed about the guidelines and regulations to follow for each Member seeking family planning and sterilization services.

In a verification study, twenty-nine (29) sterilization claims were reviewed: 25 paid claims and 4 denied claims. Claims were reviewed for compliance standards. Of the 25 paid claims reviewed, two (2) sterilization claims lacked the Informed Consent form PM 330.

**RECOMMENDATIONS:**

- Ensure that the Plan obtains a completed Informed Consent form (PM330) submitted with claims.
- Develop a system to monitor for compliance in the completion of Informed Consent forms.

## CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.5

### FRAUD AND ABUSE

#### **Fraud and Abuse Reporting**

Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse....

- 1) Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract.
- 2) Contractor shall provide effective training and education for the compliance officer and all employees.
- 3) Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines.
- 4) Fraud and Abuse Reporting—Contractor shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity....
- 5) Tracking Suspended Providers—Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs....

2-Plan Contract E.2.26.B

#### **SUMMARY OF FINDINGS:**

The Plan's Policies, *Fraud, Waste, and Abuse Program (MC\_23B)* and *Fraud, Waste, and Abuse Program—Reporting Procedures—State Program (PRO\_CMP03b)* establish the Plan's system for the prevention and reporting of fraud, waste, and abuse for its internal and external operations.

Suspected fraud, waste, and abuse cases can be reported to the Plan's Compliance Officer or Compliance Department by phone, email, fax, and mail. The Compliance Department will conduct and complete the preliminary investigation of the suspected activities within ten (10) working days after receiving a report of suspected fraud, waste, or abuse.

The Compliance Department will complete a MC609 for submission to the Department of Health Care Services (DHCS) Program Integrity Unit (PIU) and DHCS Investigations Branch within 10 working days after the Plan becomes aware of or is on notice of such suspected activities. DHCS Investigation Branch provides status updates and meets regularly with the Plan.

As part of the credentialing or re-credentialing process all providers are cross-referenced to both lists, the Office of Inspector General (OIG) List of Excluded Individuals/Entities and the Medi-Cal Suspended and Ineligible Provider List. The Plan performs the verification process monthly. Also, the Plan's Claim Department denies claims by tracking suspended, excluded, or terminated providers from participation in the Medi-Cal program.

The Plan informs all employees through a Code of Business Conduct about fraud, waste, and abuse prevention, identification, and reporting methods to report suspect activities.

Members are informed through the Member Handbook, Member Newsletter, and the Plan's website, to report any

wrongdoing or fraud to the Plan by email, fax, or mail or by calling the Compliance Hotline.

Providers are informed through the Plan's website to have systems in place to identify fraud and/or abuse and to take appropriate action to report suspect fraud, waste, and abuse to Compliance Department by mail, email, phone, or fax.

The Contract stipulates that all cases of suspected fraud and/or abuse should be reported within ten (10) working days. Seven (7) Fraud and Abuse cases were reviewed. The Plan reported five (5) fraud and abuse cases to the DHCS within the timeframe of ten (10) working days to comply with contractual requirements. One (1) case was not reported at all. (Contract Reference: 2-Plan Exhibit E, Attachment 2.26.B)

**RECOMMENDATION:**

Ensure that all suspected fraud and abuse cases are reported to Department of Health Care Services within the 10 working day limit.

MEDICAL REVIEW – SOUTHERN SECTION III  
AUDITS AND INVESTIGATIONS  
DEPARTMENT OF HEALTH CARE SERVICES

## **Inland Empire Health Plan**

Contract Number: 03-75797  
State Supported Services

Audit Period: January 1, 2013  
Through  
December 31, 2013

Report Issued:  
November 13, 2014

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II. COMPLIANCE AUDIT FINDINGS .....2

## **INTRODUCTION**

The audit report presents findings of the contract compliance audit of Inland Empire Health Plan and its implementation of the State Supported Services contract with the State of California. The State Supported Services contract covers abortion services for Inland Empire Health Plan.

The on-site audit was conducted from April 7, 2014 through April 18, 2014. The audit covered the review period from January 1, 2013 through December 31, 2013 and consisted of document review of materials supplied by the Plan.

An Exit Conference was held on October 1, 2014 with the Plan. The Plan was allowed 15 calendar days from the date of the exit conference to provide supplemental information addressing the draft audit report finding. No additional information was submitted following the exit conference.

**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

PLAN: **Inland Empire Health Plan**

AUDIT PERIOD: Jan.1, 2013 through Dec. 31, 2013

DATE OF AUDIT: April 7, 2014 through April 18, 2014

**STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS**

**Abortion**

*Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:  
Current Procedural Coding System Codes\*: 59840 through 59857  
HCFA Common Procedure Coding System Codes\*: X1516, X1518, X7724, X7726, Z0336*

*\*These codes are subject to change upon the Department of Health Care Services' (DHCS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.  
State Supported Services Contract Exhibit A.1*

**SUMMARY OF FINDINGS:**

Abortion is a sensitive service and is covered by the Medi-Cal program as a physician service. Medical justification and prior authorization is not required. The Plan must provide abortion services from any contracted or non-contracted provider. The Plan has policies related to sensitive services for its Claims Department and for Providers.

The Plan's Provider policy and procedure manual, *Access to Sensitive Services* (MC\_09E) informs Providers that Members can obtain sensitive services without prior authorization through any qualified practitioner contracted with the Member's Independent Physician Association. Minors may obtain sensitive services without parental consent through a practitioner other than the Primary Care Physician. Members, regardless of age, may obtain information regarding access to care and assistance with appointment scheduling for sensitive services through Inland Empire Health Plan's Member Services or their Primary Care Physician's office.

The Plan's Claims Department policies and procedures manual, *State Supported Services, Abortion* (OPS/CLM P-13) includes updated Correct Procedural Terminology Codes (CPT) 59812-59857, Diagnosis Codes 635. - 637.99 and Healthcare Common Procedural Coding System Codes (HCPCS) S0199, S0190 and S0191 as billable codes for abortion services according to contractual requirement. Members have the right to access sensitive services through a contracted or non-contracted qualified provider.

The Plan's Provider policy and procedure Manual (MC\_09E) did not include language that Members have the right to access sensitive services through a contracted or non-contracted qualified provider. The policy states that sensitive services can be obtained through any qualified practitioner *contracted with the Member's IPA* (MC\_09.3).

According to Plan personnel, the Claims Department policies and procedures manual (OPS/CLM P-13) superseded Provider policy and procedure manual (MC\_09E).

Members have the right to choose and access sensitive service including abortion service without prior authorization. Members may self-refer to a contracted or non-contracted Provider. The Member Handbook informs Members that minors do not need an adult consent or referral to access pregnancy termination services.

**RECOMMENDATION:**

Update the language in the Provider policy and procedure manual, *Access to Sensitive Services* (MC\_09E) to include the contractual stipulation that Members have the right to access sensitive services through a contracted or non-contracted qualified provider.